

**MARKET CONDUCT REPORT ON EXAMINATION**

**OF**

**EMPIRE HEALTHCHOICE ASSURANCE, INC.**

**AND**

**EMPIRE HEALTHCHOICE HMO, INC.**

**AS OF**

**DECEMBER 31, 2006**

**DATE OF REPORT**

**NOVEMBER 4, 2010**

**EXAMINER**

**PEARSON GRIFFITH**

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STATE OF NEW YORK  
INSURANCE DEPARTMENT  
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David A. Paterson  
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James J. Wrynn  
Superintendent

November 4, 2010

Honorable James J. Wrynn  
Superintendent of Insurance  
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Numbers 22488 and 22489, dated March 10, 2006, attached hereto, I have made an examination into the affairs of Empire HealthChoice Assurance, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law and its wholly-owned subsidiary, Empire HealthChoice HMO, Inc., a for-profit health maintenance organization licensed under Article 44 of the New York Public Health Law, respectively, as of December 31, 2006, and submit the following report thereon.

The examination was conducted at the administrative office of Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc., located at 15 MetroTech Center, Brooklyn, New York.

Wherever the designations "EHCA" or the "Company" appear herein, without qualification, they should be understood to indicate Empire HealthChoice Assurance, Inc.

Wherever the designations “EHC-HMO” or the “Plan” appear herein, without qualification, they should be understood to indicate Empire HealthChoice HMO, Inc.

Wherever the designations “Empire” or the “Companies” appear herein, without qualification, they should be understood to indicate EHCA and EHC-HMO, collectively.

Wherever the designation, the “Department” appears herein, without qualification, it should be understood to indicate the New York State Insurance Department.

## 1. SCOPE OF THE EXAMINATION

The previous market conduct examination was conducted as of March 31, 2003. This examination covers the period April 1, 2003 to December 31, 2006, and was performed to review the manner in which Empire conducts its business practices and fulfills its contractual obligations to policyholders and claimants. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

A review was also made to ascertain what actions were taken by the Companies with regard to comments and recommendations made in the prior market conduct reports on examination.

Separate examinations regarding the financial condition of EHCA and EHC-HMO were conducted by this Department as of December 31, 2006. The resulting reports on examination were filed on June 30, 2009.

Further, the Department conducted a special market conduct examination that targeted Empire's rating practices for its large group experience rated business, which also entailed a review of the compensation for agents and brokers involved with the selling of this product. The examination covered the period January 1, 2003 to September 30, 2004. The resulting report on examination was filed on May 22, 2007.

## 2. **EXECUTIVE SUMMARY**

The results of this examination revealed certain operational deficiencies that indicated areas of weakness and/or directly impacted the Companies' compliance with the New York Insurance Law, its Regulations and Circular Letters, and the New York Public Health Law. The most significant findings relative to this examination include the following:

- Maintenance of licenses for all agents and broker appointees.
- Ensuring that certificates of appointment for each of its agents are on file with the Department.
- Maintaining a log of terminated agents and to ensure that such terminations are reported to the Department.
- Clarification of the provisions of the New York Insurance Law and New York Public Health Law pertaining to Utilization Review.
- Practices regarding compliance with certain provisions of the New York Insurance Law pertaining to Grievance procedures.
- Compliance with the standards for prompt, fair and equitable settlement of claims for health care and payments for health care services ("Prompt Pay Law").

The above findings are described in greater detail in the remainder of this report.

## 3. **DESCRIPTION OF THE COMPANIES**

Effective November 2002, Empire Blue Cross and Blue Shield converted from a non-profit company licensed pursuant to Article 43 of the New York Insurance Law to a for-profit accident and health insurer, licensed pursuant to Article 42 of the New York Insurance Law, and changed its name to Empire HealthChoice Assurance, Inc.

Simultaneously with the conversion, Empire Blue Cross and Blue Shield merged with its then Article 42 subsidiary, Empire HealthChoice, Inc. As a result of the conversion, a new entity named WellChoice Holdings of New York, Inc. was established. This new entity was owned by WellChoice, Inc. (“WellChoice”), which in turn owned EHCA and EHC-HMO.

On September 27, 2005, representatives of WellPoint, Inc. (“WellPoint”) and WellChoice announced their intention to enter into a definitive merger agreement. Under the terms of the agreement, WellPoint agreed to acquire all of the outstanding shares of WellChoice. On December 28, 2005, WellPoint completed its acquisition of WellChoice. WellChoice merged with and into WellPoint Holding Corp., a direct and wholly-owned subsidiary of WellPoint; with WellPoint Holding Corp. as the surviving entity in the merger.

As a result of the transactions described above, Wellchoice, Inc. (“Wellchoice”), a Delaware corporation and ultimate parent of EHCA and EHC-HMO, merged with and into Wellpoint Holding Corp., the name of the surviving corporate entity. After completion of the merger, the ultimate parent of EHCA was Wellpoint.

EHCA wholly owns EHC-HMO and WellChoice Insurance of New Jersey, Inc. (“WCINJ”). EHC-HMO is a health maintenance organization licensed pursuant to the provisions of Article 44 of the New York Public Health Law, which is also licensed to operate in the State of New Jersey. WCINJ is a credit, life and health insurance company licensed in eleven states, however, as of the examination date it wrote business only in New Jersey.

Subsequent to the examination date, WCINJ was dissolved on October 28, 2008, and WellChoice HMO of New Jersey surrendered its certificate of authority from New Jersey on July 7, 2008.

The Company continues to do business as Empire Blue Cross and Blue Shield in the State of New York and remains the owner of Empire HealthChoice HMO, Inc.

Unless otherwise noted, the findings contained herein relate to both EHCA's operations as an Insurance Law Article 42 insurer and EHC-HMO's operations as an Article 44 New York Public Health Law health maintenance organization.

**4. ADOPTION OF PROCEDURE MANUALS – DEPARTMENT CIRCULAR**

**LETTER NO. 9 (1999)**

Department Circular Letter No. 9 (1999), dated May 25, 1999, "Adoption of Procedure Manuals" was issued to Article 43 Corporations, Public Health Law Article 44 Health Maintenance Organizations and insurers licensed to write health insurance in New York State.

The Circular Letter states in part:

"...it is recommended that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations..."

Department Circular Letter No. 9 (1999) recommends that the adoption of written procedures enable the board to assure itself that the companies' operations in other key areas are being conducted in accordance with applicable statutes, rules and regulations. Examples of these additional key areas include: implementation of the Managed Care Bill of Rights (e.g., information dissemination, accessing prompt quality care, grievance/appeal process), underwriting and rating, external appeals and the accurate and timely reporting of all financial statement schedules and exhibits. Therefore, the previously recommended annual certification to the board regarding implementation of the adopted procedures and the board's need to oversee outside parties under contract with the Companies, also extends to these additional areas.

A review of the minutes of the meetings of the Companies' boards of directors through December 31, 2006 revealed that the additional annual certifications did not include other key areas as delineated above. When this deficiency was brought to its attention, Empire agreed to further expand its Circular Letter No. 9 updates to include these operations, beginning with the 2007 board certifications. Similar findings were also noted in the Department's Special Market Conduct Examination report of Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc. (collectively "Empire") as of September 30, 2004 (report filed May 22, 2007.)

Subsequent to the filing of the Special Market Conduct Examination report, Empire revised its processes to address the recommendation regarding Circular Letter No. 9 (1999) contained in that report.

## 5. SALES, MARKETING AND ADVERTISING

### A. Review of the Companies' Website

The examiner reviewed Empire's website to ensure the proper disclosure of who is selling, advertising and servicing the site, the services sold, the physical location of the Companies, and the ability of users to research and/or request more information about a particular product.

After reviewing the Spanish language link of Empire's website, implemented in December 2006, the examiner noted that the Spanish link used for locating a medical provider, pharmacist, etc., led to an English language site. This situation may cause confusion for a (Spanish-speaking) member or prospective member when selecting or researching a provider, or in making well-informed choices and decisions. The examiner requested additional information regarding the Companies' policy on the issuance of subscriber information on non-English websites. The Companies responded that they do not have such a policy.

It is recommended that, where appropriate, the Companies provide linked information in Spanish on their website, in order to prevent any communication problems with Spanish-speaking members or prospective members.

A review of Empire's provider finder in June 2010 showed a link that goes directly to a Spanish translation of the website reflecting compliance with this recommendation.

B. Advertising

The examiner requested and reviewed copies of Empire's advertising and sales materials in both hard copy and electronic form; as well as copies of the policy forms that pertain to selected advertisements. Advertising materials and policy forms were reviewed to ensure that the information contained in both were in compliance with applicable statutes and that the information matched. The examiner reviewed a listing of all advertising and sales materials published, as well as the Companies' procedures for agents advertising on the internet.

The examiner noticed that one of Empire's advertisements appeared to be vague, in terms of its language, and that the Companies used statistics that were not referenced to their source. Specifically, the examiner noted that one advertisement stated in part: "...85% of them would also recommend us to other doctors", without providing the source of the statistical citation.

Department Regulation No. 34 (11 NYCRR 215.9(c)) states:

"The source of any statistics used in an advertisement shall be identified in such advertisement."

It is recommended that Empire comply with the provisions of Department Regulation No. 34 and provide specific references for any statistics used in advertisements and that the Companies refrain from using vague terms in their advertisements.

## 6. AGENTS AND BROKERS

A review was performed of Empire's sales distribution system. During the period covered by the examination, the Companies utilized internal and external producers, which consisted of both agents and brokers.

### A. Agents' Licensing and Certificates of Appointments

The examiner selected a sample of twenty agents for review to determine if valid licenses were on file with Empire and that it filed certificates of appointments with the Department, pursuant to the requirements of Section 2116 of the New York Insurance Law.

Section 2116 of the New York Insurance Law states in part:

"No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article..."

Section 2102(a)(1) of the New York Insurance Law states:

"No person, firm, association or corporation shall act as an insurance producer or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter."

Empire did not maintain valid licenses for one of the twenty agents sampled, in violation of the requirements of Section 2116 of the New York Insurance Law. Specifically, the Companies could not locate a license for one agent that received commission payments between January 1, 2005 and June 30, 2005. In addition, the

Companies could not verify whether another agent was licensed when she received commission payments in July 2005. Further, Empire was unable to provide supporting documentation to verify the effective date of licensure of a third agent.

It is recommended that Empire maintain current licenses on file for all active producers to ensure compliance with the provisions of Section 2116 of the New York Insurance Law.

Subsequent to the examination date, Empire provided verification that the agent had been properly licensed with the Department since 1996.

Section 2112(a) of the New York Insurance Law states:

“Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization.”

The examiner requested certificates of appointment for each of the twenty agents selected for review. The Companies were unable to produce certificates of appointments for three of the twenty agents selected. It was determined that two of these agents were not appointed due to the loss of paperwork from the events of September 11, 2001. Subsequent to the date of this examination, the two agents were reappointed. However, Empire failed to note that the third agent had not provided a valid (renewal) license since June 30, 2005. The Companies decided to terminate the appointment of this agent.

It is recommended that Empire ensure that certificates of appointments are filed with the Department for each of its agents, as required by Section 2112(a) of the New

York Insurance Law. The Companies should also ensure that commission payments are made only to agents that have been appointed by Empire.

B. Termination of Agents

During a review of Empire's process for terminating its agents, it appeared that Empire did not maintain its own log of agents and brokers whose certificates of appointments were terminated. Best business practices dictate that Empire should maintain a log of terminated certificates of appointments of agents and brokers and that such log include the reason(s) for termination.

Section 2112(d) of the New York Insurance Law states in part:

“Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause...”

According to Empire's appointment and termination procedures, the agents' appointment and termination confirmation pages are downloaded and printed from the Department's website, and then imaged and maintained with Empire's records. However, the examiner noted that certain appointment and termination notices were not available for review. Empire subsequently downloaded and printed the appointment confirmations. It appears that Empire is not consistently following its policy and procedures regarding producer appointment and termination processing.

Department Regulation No. 152 (11 NYCRR 243.2) states in part:

“(a) In addition to any other requirement contained in Insurance Law Section 325, any other Section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.

(b) Except as otherwise required by law or regulation, an insurer shall maintain...

(5) A licensing record for six calendar years after the relationship is terminated for each Insurance Law licensee with which the insurer establishes a relationship. Licensing records shall be maintained so as to show clearly the dates of appointment and termination of each licensee...”

It is recommended that Empire comply with the provisions of Section 2112(d) of the New York Insurance Law by maintaining documentation for and reporting all terminated insurance agents to the Department, as prescribed by statute.

It is also recommended that Empire maintain a log of terminated certificates of appointments of agents and brokers in accordance with the recordkeeping requirements of Department Regulation No. 152.

Empire stated that it did not terminate anyone for cause during the examination period.

## 7. UTILIZATION REVIEW

Sections 4902, 4903 and 4904 of the New York Insurance Law set forth the minimum utilization review program standards, requirements of utilization review determinations for prospective, concurrent and retrospective reviews and appeals of adverse determinations by utilization review agents, respectively, for insurers, such as EHCA, licensed under Article 42 of the New York Insurance Law. Comparable sections of Article 49 of the New York Public Health Law contain the same requirements for HMOs licensed under Article 44 of the Public Health Law and thus would be applicable to EHC-HMO. For ease of reading, the findings detailed herein refer to the New York Insurance Law. However, unless otherwise noted, the violations are applicable to the comparable statutory citations of Article 49 of the New York Public Health Law (for EHC-HMO).

The Companies' utilization review timeframes for Precertification of Non-Urgent Care of "3 business days not to exceed 15 calendar days from receipt of request", for decision making, verbal communication and written communication does not fully comply with the requirements of Section 4903(b) of the New York Insurance Law.

Section 4903(b) of the New York Insurance Law states:

"A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

Thus, the language in Empire's policy stated above does not comply with the aforementioned statute because it fails to specify that a determination shall be made and notice provided within three business days of receipt of the necessary information.

However, Empire indicates that it interprets Section 4903(b) to mean that a utilization review agent must provide notice of a determination involving a request for pre-authorization of non-urgent care within 3 business days of receipt of the necessary clinical information. Further, Empire indicates that it interprets the federal Department of Labor (DOL) claims procedure regulation (29 CFR §503-1(f)(2)(iii)(A)) for pre-service claims to mean that a request for pre-authorization of non-urgent care must be completed within 15 calendar days of the receipt of the request, with additional time permitted if the request is incomplete).

Although Empire asserts that the language in its policy is an attempt to reconcile and satisfy both the state and federal statutory requirements mentioned above, its policy is not clear in that it does not note that the shortest timeframe (New York Insurance Law or Department of Labor regulation) attached to the applicable statute should be utilized.

It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services requiring pre-authorization by clearly delineating when the state or federal statutory timeframes should be applied to a particular pre-service claim.

In addition, Empire's policy provides timeframes for determinations on retrospective reviews (post service) of 30 calendar days. However, Empire stated, "If additional information was needed, it would allow up to 45 calendar days for the response to a request for additional information."

Section 4903(d) of the New York Insurance Law states:

“A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.”

Similar to the above-mentioned circumstance, Empire interprets the above statute to mean that a utilization review agent shall issue a determination, involving services which have been delivered, within 30 calendar days of receipt of the necessary clinical information. Further, Empire interprets the federal Department of Labor (DOL) claims procedure regulation for post-service claims (29 CFR § 503-1(f)(2)(iii)(B)), to mean that it must advise a claimant within 30 days of its receipt of a claim that additional information is necessary to decide the claim, and shall afford at least 45 calendar days to provide the specified information.

Although Empire’s implementation of the foregoing appears to satisfy both the state and federal statutory requirements mentioned above, its policy is not clear, in that it does not note that the shortest timeframe (New York Insurance Law or Department of Labor regulation) attached to the applicable statute should be utilized.

It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services which have been delivered, by clearly delineating when the state or federal statutory timeframes should be applied to a particular post-service claim.

Empire has two different appeal levels for pre-service claims. *For Level 1 - Medical Director*, Empire provided a determination timeframe for expedited appeals of

adverse determinations of “2 business days of receipt of all necessary information, but not to exceed 72 hours from the request.”

Section 4904(b) of the New York Insurance Law states in part:

“...Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal...”

New York Insurance Law Section 4904(b) requires expedited appeals to be determined within two business days of receipt of necessary information, whereas the applicable DOL regulation requires expedited appeals to be determined within 72 hours of receipt of the request for an expedited appeal.

It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim.

*For Level 2 - Medical Director*, Empire stated that a second level of expedited appeals is not applicable for pre-service claims since the appealing party may further request a standard appeal following an expedited appeal or request an external review with the New York Insurance Department. However, there appears to be two timeframes listed in the policy section, “Decision turnaround”, for standard appeals contained in *Attachment B of Empire’s Managed Care Policy & Procedure*. In one section, Empire provides a timeframe for a standard appeal determination of “60 calendar days from receipt of all necessary information.” Further, in another section, Empire provides a timeframe for a standard appeal determination of “15 calendar days from receipt of appeal request.”

Empire contends that its policy is in compliance with both the New York Insurance Law and the applicable DOL regulations. For expedited appeals, only one level of (expedited) review is available. After an expedited appeal, a standard appeal can be filed, or an external appeal can be filed. If a standard appeal is filed after an expedited appeal, it is determined within 60 days of receipt of necessary information, pursuant to New York Insurance Law Section 4904(c).

For standard (non-expedited) appeals relating to pre-service reviews, the DOL regulations require that appeals be determined within 30 days of receipt of the request for an appeal, while the Insurance Law requires standard appeals to be determined within 60 days of receipt of necessary information. The DOL regulations also require that if a Company offers two levels of appeal, each appeal must be determined within 15 days. Thus, in order to comply with DOL regulations, standard appeals relating to pre-service reviews must be determined within 30 days if there is one level of appeal or 15 days if there are two levels of appeal. This complies with the New York Insurance Law requirement that the appeal be determined within 60 days.

This is another example whereby Empire's policy may cause confusion because it provides two different timeframes.

It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim.

*For Level 1 - Medical Director*, Empire provides a timeframe for written communication decisions for expedited appeals of adverse determinations of, “within 24 hours of determination, but not to exceed 72 hours from the request.”

Section 4904(c) of the New York Insurance Law states in part:

“...The utilization review agent shall notify the insured, the insured’s designee and, where appropriate, the insured’s health care provider, in writing of the appeal determination within two business days of the rendering of such determination...”

Empire failed to notify the insured, the insured’s designee or (where appropriate) the insured’s health care provider in writing, of the appeal determination, within two business days of the rendering of such determination in four of the thirty cases the examiner reviewed.

It is recommended that Empire comply with the requirements of Section 4904(c) of the New York Insurance Law.

Again, Empire contended that its policy was in compliance with both the New York Insurance Law and the applicable DOL regulation. However, an *urgent care appeal*, as the term is used in the DOL regulation differs from an *expedited appeal*, as the term is defined in the New York Insurance Law. Empire needs to address this difference in its policy – specifically noting that if an appeal is both expedited and urgent – the shortest timeframe (New York Insurance Law or DOL regulation) should apply.

It is recommended that Empire amend its Utilization Review procedures to clearly note which statute is applicable to a specific situation.

In addition to the previous comments regarding the integration/delineation of the utilization review requirements mandated by the Insurance Law and Department of Labor regulations, it was noted that the policies regarding utilization review provided by Empire were marked Anthem UM Services, Inc. (an Empire affiliate). Though Empire contends that it has adopted these policies – it should formally document that these policies were in fact adopted by EHCA and EHC-HMO.

The examination review also included a verification of the Companies' compliance with the reporting requirements for utilization review agents.

Section 4901(a) of the New York Insurance Law states:

“Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section.”

In addition, Section 4901(1) of the New York Public Health Law states:

“Every utilization review agent who conducts the practice of utilization review shall biennially register with the commissioner and report, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subdivision two of this section.”

Empire was unable to provide any documentation to confirm that the requisite statements were filed with the Superintendent of Insurance or the Commissioner of Health during the examination period. Empire's response to the examination request indicated that no internal documentation was available. Empire also advised the examiner that a Freedom of Information Law request was submitted to the Insurance Department to obtain these statements.

Part 243.2(a) of Department Regulation No. 152 (11 NYCRR 243.2(a)) states:

“(a) In addition to any other requirement contained in Insurance Law Section 325, any other Section of the Insurance Law or other law, or any other provision of this Title, every insurer shall maintain its claims, rating, underwriting, marketing, complaint, financial, and producer licensing records, and such other records subject to examination by the superintendent, in accordance with the provisions of this Part.”

It is recommended that Empire complies with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law.

Subsequent to the date of this examination, Empire provided documentation to show that it was in compliance with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law.

It is also recommended that Empire complies with the provisions of Part 243.2(a) of Department Regulation No. 152, by retaining copies of all utilization review statements that are required to be filed with the Superintendent of Insurance and/or the Commissioner of Health.

A review of Empire’s *Notification of Utilization Review Determination* policy (URA-03) identifies information that will be included in written notification of an adverse determination. Section 4903(e) of the New York Insurance Law also requires the adverse determination to contain the reasons for the determination including the clinical rationale, and notice of the availability upon request of the insured or the insured’s designee of the clinical review criteria relied upon to make the determination. Empire’s notification letter is deficient in this regard.

Section 4903(e) of the New York Insurance Law states, in part:

“Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

- (1) the reasons for the determination including the clinical rationale, if any; and...
- (3) notice of the availability, upon request of the insured, or the insured’s designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal.”

It is recommended that Empire comply with the provisions of Section 4903(e) of the New York Insurance Law and revise its *Notification of Utilization Review Determination* policy (URA-03) accordingly.

A review of Empire’s *Appeals of Adverse Determinations* policy (URA-04) states that missing information will be requested within 15 calendar days of receipt of the appeal and within 5 business days of receipt of partial information. Although this policy references Health Maintenance Organizations (HMOs), the requirements are also applicable to insurers that are licensed pursuant to Articles 42 and 43 of the New York Insurance Law. While not expressly stated in its policy, Empire contends that it has been applying these requirements to the Article 42 company.

Part 410.9(b) of Department Regulation No. 166 (11 NYCRR 410.9(b)) states:

“(b) If a health care plan requires information necessary to conduct a standard internal appeal pursuant to Section 4904 of the Insurance Law, the health care plan shall notify the insured and the insured’s health care provider, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, the health care plan shall request the missing information, in writing, within five business days of receipt of the partial information. In the

case of expedited appeals, the health care plan shall immediately notify the insured and the insured's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification. The period of time to make an appeal determination under Section 4904 of the Insurance Law begins upon a health care plan's receipt of necessary information."

It is recommended that Empire expressly comply with the provisions of Department Regulation No. 166 and revise its policy in regard to utilization review *Appeals of Adverse Determinations* (URA-04) to also include insurers that are licensed pursuant to Articles 42 and 43 of the New York Insurance Law.

## **8. GRIEVANCES AND APPEALS**

A review of the explanation of benefits statements ("EOBs") sent by Magellan Health Services ("Magellan"), Empire's third party administrator for behavioral health services, states the following:

"New York State Law requires Health Plans to determine an appeal or grievance within 60 days."

This statement is not consistent with Section 4802(d)(2) of the New York Insurance Law, which states in part:

"...thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract..."

It is recommended that Magellan, which acts on behalf of Empire as a third party administrator ("TPA"), comply with the requirement of Section 4802(d)(2) of the New York Insurance Law by ensuring that resolutions to grievances filed are rendered within

the statutorily mandated 30-day period after receipt of all necessary information. Empire, which is responsible for Magellan's violations of statute, should ensure Magellan's compliance with applicable requirements.

It is also recommended that Magellan revise statements on its acknowledgement letters to members to correctly state that New York Insurance Law requires Health Plans to determine an appeal or grievance within 30 days and **not** 60 days as currently stated.

Effective January 1, 2008 – Empire no longer uses Magellan as a vendor.

A review of first and second level grievances by the examiner revealed that some paper documents received by Empire did not contain proper date stamping. Grievances sent by members and providers are date sensitive documents, and therefore should be date stamped the day Empire or its contracted TPA(s) receives these documents. Without the date stamp, the examiner was unable to verify the actual receipt date of the grievance documents. Of the 20 grievances reviewed, only one included a date stamp. Subsequent to the examination date, Empire presented a document to the examiner dated December 18, 2007, showing that effective immediately, a new policy was implemented, requiring the date stamping of all grievances received by Empire.

It is recommended that all grievances received by Empire or its TPA(s) include the proper date stamp to reflect the day that the Companies receive such documents.

Section 4802(d) of the New York Insurance Law requires that within fifteen business days of receipt of a grievance, the insurer shall provide written acknowledgement of the grievance to the member/provider. Of the nineteen grievances

reviewed by the examiner, only four were shown to have an acknowledgement letter sent to the member. The Companies were in violation of the abovementioned statutes for the fifteen cases in which Empire failed to produce a copy of the acknowledgement letters.

Additionally, the Companies stated that the acknowledgement letter is generated automatically. However, in several instances, the Companies explained that Empire's system did not generate the letters automatically, because of a "system error" that failed to generate the letters for certain departments. Empire stated that a "system fix" was implemented on August 26, 2004. However, the examination review showed that the system [still] failed to generate the required letter in certain instances after that date.

The automated generation of the acknowledgement letters for grievances should be considered a control issue as the examination revealed that the system failed to generate the letters, even after the system had been set to generate them automatically. The fact that the system fix failed to correct the problem, and that no further fix was implemented, showed that the control procedures in place were ineffective. Further, the controls in place failed to ensure that the problem could be prevented.

It is recommended that Empire comply with the requirements of Sections 4802(d) of the New York Insurance Law and ensure that acknowledgement letters are sent to members for all grievances received, within 15 business days of receipt of the application.

It is also recommended that Empire review and evaluate its controls to ensure that the automated system works correctly and sends grievance acknowledgement letters to members/providers in a timely manner.

Section 4802(d)(2) of the New York Insurance Law states in part:

“... thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract...”

The examination review of grievances was limited to nineteen selected cases that were shown to have been resolved more than thirty days after receipt of the grievance by Empire. Of the nineteen sampled cases, seventeen were actually over the thirty day resolution period required by statute.

The Companies failed to comply with the provisions of the New York Insurance Law which requires that all grievances be resolved no more than thirty days after receipt of all necessary information (in the case of requests for referrals or determinations concerning whether a request is covered pursuant to the contract) and 45 days after receipt of all necessary information in all other instances.

It is recommended that Empire comply with the provisions of Section 4802(d)(2) of the New York Insurance Law by ensuring that resolutions to grievances filed are rendered within thirty days (after receipt of all necessary information).

**9. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH SERVICES (“PROMPT PAY LAW”)**

Section 3224-a of the New York Insurance Law, “Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services” (“Prompt Pay Law”), requires all insurers to pay undisputed claims within 45 days of receipt. If such undisputed claims are not paid within 45 days of receipt, interest may be

payable.

Section 3224-a(a) of the New York Insurance Law states:

“(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered.”

In addition, Section 3224-a(c) of the New York Insurance Law states:

“(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim.”

A statistical sample of claims not adjudicated within 45 days of receipt by the Companies was reviewed to determine whether the claims were processed in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law (“NYIL”), and if interest was required and appropriately paid pursuant to Section 3224-a(c) of the NYIL. Accordingly, all claims that were not adjudicated within 45 days during the period January 1, 2003 through December 31, 2006, were segregated. A statistical sample of this population was then selected to determine whether the claims

were subject to interest, and whether such interest was properly calculated.

The claim populations for the Company and EHC-HMO were separated and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment, for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by Empire as “Pharmacy,” “Medicare/Medicaid,” “Dental,” “Capitated Payments,” “Federal Employees Program” and “HCRA bulk payments,” were excluded from the examiner’s review.

The sample size for each population was comprised of 167 randomly selected unique claims. Additional random samples were generated for each group as “replacement items” in the event it was determined that a particular claim transaction selected in the sample was excluded. Accordingly, various replacement items were appropriately utilized. In total, 668 claims were selected for this review (334 from the Company and 334 from the Plan (167 each from the medical and hospital claim segments)).

The following charts illustrate the Companies’ compliance with the Prompt Pay Law, as determined by this examination:

**EHCA - Summary of Violations of Section 3224-a(a) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	10,315,919	3,396,980
Population of claims adjudicated past 45 days	212,800	112,333
Sample size	167	167
Number of claims with violations	67	47
<b>Calculated violation rate</b>	<b>40.12%</b>	<b>28.14%</b>
Upper violation limit	47.55%	34.96%
Lower violation limit	32.69%	21.32%
<b>Calculated claims in violation</b>	<b>85,375</b>	<b>31,615</b>
Upper limit claims in violation	101,194	39,276
Lower limit claims in violation	69,555	23,953

**Note:** The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

**EHCA - Summary of Violations of Section 3224-a(c) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	10,315,919	3,396,980
Population of claims paid past 45 days that are eligible for interest	212,800	112,333
Sample size	167	167
Number of transactions with violations	27	35
<b>Calculated violation rate</b>	<b>16.17%</b>	<b>20.96%</b>
Upper violation limit	21.75%	27.13%
Lower violation limit	10.58%	14.78%
<b>Calculated transactions in violation</b>	<b>34,405</b>	<b>23,543</b>
Upper limit transactions in violation	46,287	30,477
Lower limit transactions in violation	22,523	16,608

**Note:** The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

**EHC-HMO - Summary of Violations of Section 3224-a(a) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	6,549,812	638,095
Population of claims adjudicated over 45 days	196,805	34,446
Sample size	167	167
Number of claims with violations	75	76
<b>Calculated violation rate</b>	<b>44.91%</b>	<b>45.51%</b>
Upper violation limit	52.45%	53.06%
Lower violation limit	37.37%	37.96%
<b>Calculated claims in violation</b>	<b>88,385</b>	<b>15,676</b>
Upper limit claims in violation	103,233	18,278
Lower limit claims in violation	73,538	13,074

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

**EHC-HMO - Summary of Violations of Section 3224-a(c) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	6,549,812	638,095
Population of claims paid over 45 days that are eligible for interest	196,805	34,446
Sample Size	167	167
Number of claims with violations	29	45
<b>Calculated violation rate</b>	<b>17.37%</b>	<b>26.95%</b>
Upper violation limit	23.11%	33.68%
Lower violation limit	11.62%	20.22%
<b>Calculated transactions in violation</b>	<b>34,176</b>	<b>9,282</b>
Upper limit transactions in violation	45,483	11,600
Lower limit transactions in violation	22,868	6,964

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated over forty-five days from receipt and/or those claims adjudicated during the period January 1, 2003 through December 31, 2006, which should have incurred interest of two dollars or more based upon the examiner's calculations.

The population of claims adjudicated after forty-five days from the date of receipt for ECHA consisted of 212,800 and 112,333 medical and hospital claims, respectively, out of 10,315,919 and 3,396,980 medical and hospital claims processed, respectively, during the period under review.

The population of claims paid after forty-five days from the date of receipt for EHC-HMO consisted of 196,805 and 34,446 medical and hospital claims, respectively, out of 6,549,812 and 638,095 medical and hospital claims processed, respectively, during the period under review.

It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with.

It is also recommended that Empire take steps to ensure that the provisions of Section 3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with.

A review was also performed as to the manner in which the Companies handled the denial of claims that they were not obligated to pay, or to request additional information needed to determine liability to pay a claim.

Section 3224-a(b) of the New York Insurance Law states:

“(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

(1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment.

Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.”

A statistical sample of claims denied more than 30 days after receipt by the Companies was reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims that were not denied within 30 days during the period January 1, 2003 through December 31, 2006, were segregated. A statistical sample of this population was then selected to determine whether the claims were properly denied, as required by statute.

The following charts illustrate the Companies' compliance with Section 3224-a(b) of the New York Insurance Law, as determined by this examination:

**EHCA - Summary of Violations of Section 3224-a(b) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	10,315,919	3,396,980
Population of claims adjudicated over 30 days	300,773	128,054
Sample size	167	167
Number of claims with violations	14	15
<b>Calculated violation rate</b>	<b>8.38%</b>	<b>8.98%</b>
Upper violation limit	12.59%	13.32%
Lower violation limit	4.18%	4.65%
<b>Calculated claims in violation</b>	<b>25,215</b>	<b>11,502</b>
Upper limit claims in violation	37,857	17,055
Lower limit claims in violation	12,572	5,949

**Note:** The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected the rate of violation would fall between these limits 95 times).

**EHC-HMO - Summary of Violations of Section 3224-a(b) of the New York Insurance Law**

	Medical Claims	Hospital Claims
Total population of claims	6,549,812	638,095
Population of claims adjudicated over 30 days	287,815	28,234
Sample size	167	167
Number of claims with violations	7	16
<b>Calculated violation rate</b>	<b>4.19%</b>	<b>9.58%</b>
Upper violation limit	7.23%	14.04%
Lower violation limit	1.15%	5.12%
<b>Calculated claims in violation</b>	<b>12,064</b>	<b>2,705</b>
Upper limit claims in violation	20,812	3,965
Lower limit claims in violation	3,316	1,445

**Note:** The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected the rate of violation would fall between these limits 95 times).

It is noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims that were denied more than thirty days from receipt.

The population of claims denied more than thirty days from the date of receipt for ECHA consisted of 300,773 and 128,054 medical and hospital claims, respectively, out of 10,315,919 and 3,396,980 medical and hospital claims processed, respectively, during the period under review.

The population of claims denied more than thirty days from the date of receipt for EHC-HMO consisted of 287,815 and 28,234 medical and hospital claims, respectively, out of 6,549,812 and 638,095 medical and hospital claims processed, respectively, during the period under review.

It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(b) of the New York Insurance Law, regarding the prompt denial of claims/requests for information are fully implemented and complied with.

During the claims review, the examiner noted that “clean” hospital claims belonging to member hospitals of the Greater New York Hospital Association (GNYHA) were to be subject to prompt pay interest penalties if not paid within thirty (30) days of receipt. This fact was not disclosed by Empire until after the examiner had selected the data fields for the claim population and the corresponding claims data file was produced and provided by Empire. The examiner was advised by Empire that GNYHA member claims could not be segregated from the hospital claims data file. As a result, the EHCA and EHC-HMO hospital claims samples contained a number of GNYHA member claims.

The hospital claims in the above charts include thirty (30) GNYHA claims in the EHCA sample and thirty-seven (37) GNYHA claims in the EHC-HMO sample. It should be noted that all claims in the above samples exceeded the payment requirements of Sections 3224-a(a) and 3224-a(c) of the New York Insurance Law.

Due to the limitations of the data provided by Empire, compliance with the 30 day Prompt Pay requirement for GNYHA claims could not be specifically determined.

It is recommended that Empire facilitate the examination process by informing the examiner of relevant operation protocols in a timely manner.

**10. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT ON**  
**EXAMINATION**

The prior market conduct report on examination contained twenty-seven (27) comments and recommendations detailed as follows (page numbers refer to the prior report on examination).

<b><u>ITEM NO.</u></b>	<b><u>PAGE NO.</u></b>
<u>Adoption of Procedure Manuals - Circular Letter No. 9 (1999)</u>	
1. It is recommended that the Company obtain the annual certifications pursuant to Circular Letter No. 9 (1999). <i>The Company has complied with this recommendation.</i>	5
<u>Agents and Brokers</u>	
2. It is recommended that Empire maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York State Insurance Law. <i>The Company has not complied with this recommendation. A similar recommendation is contained in this report.</i>	6
3. It is recommended that Empire ensure that certificates of appointments are on file with the Department for each of its agents as required by §2112(a) of the New York State Insurance Law and that commission payments are made only to those agents that have been appointed by Empire. <i>The Company has not complied with this recommendation. A similar recommendation is contained in this report.</i>	7
4. It is recommended that Empire aggressively pursue the recovery of any broker agreements and licenses that are missing. <i>The Company has complied with this recommendation.</i>	7

<u>ITEM NO.</u>		<u>PAGE NO.</u>
5.	It is recommended that the HMO comply with Regulation No. 62 (11 NYCRR 52.42(e)) and ensure that broker commissions do not exceed the 4% limitation.  <i>The Plan has complied with this recommendation.</i>	9
	<u>Disclosure of Information</u>	
6.	It is recommended that the HMO ensure that its handbooks contain all disclosure notices required by §4408(1)(c)(v) of the New York State Public Health Law.  <i>The Plan has complied with this recommendation.</i>	10
	<u>Grievances and Appeals</u>	
7.	It is recommended that the HMO provide a written acknowledgement within 15 business days for grievances filed as required by §4408-a(4) of the New York State New York State Public Health Law.  <i>The Plan has complied with this recommendation.</i>	12
8.	It is recommended that the HMO resolve grievances within thirty days when the grievance pertains to questions of coverage as required by §4408-a (4)(ii) of the New York State Public Health Law.  <i>The Plan has complied with this recommendation.</i>	12
9.	It is recommended that the HMO resolve grievances within forty-five days for grievances pertaining to issues other than questions of coverage as required by §4408-a (4)(iii) of the New York State Public Health Law.  <i>The Plan has complied with this recommendation.</i>	12
	<u>Utilization Review</u>	
10.	It is recommended that the Company comply with §4903(b) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide notice of determination within three business days by telephone and in writing to the insured/insured's designee and the provider on prospective reviews.  <i>The Companies have complied with this recommendation.</i>	14

<u>ITEM NO.</u>		<u>PAGE NO.</u>
11.	It is recommended that the Company comply with §4904(c) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide written acknowledgement within 15 days of receipt of an appeal of a utilization review determination.  <i>The Companies have complied with this recommendation.</i>	15
12.	It is recommended that the HMO comply with §4904(3) of the New York State Public Health Law and complete utilization review appeal determinations within sixty days of receipt of all required information.  <i>The Plan has complied with this recommendation.</i>	15
13.	It is recommended that the Company comply with §4904(c) of the New York State Insurance Law and the HMO comply with the equivalent citation in the Public Health Law and provide the enrollee notice of the appeal determination within 2 business days of the rendering of such determination.  <i>The Companies have complied with this recommendation.</i>	16
14.	It is recommended that the HMO comply with §4903(3) of the New York State Public Health Law and provide notice of determination within one business day of receipt of all necessary information on concurrent reviews.  <i>The Plan has complied with this recommendation.</i>	16
	<u>Contracts and Policy Forms</u>	
15.	The review found that one policy form originally filed and approved for the Article 43 corporation Empire Blue Cross and Blue Shield had not been approved by the Department for use by Empire when it converted to an Article 42 accident and health corporation in 2002. Empire states the form has not been sold to any new subscribers since it converted to an Article 42 accident and health insurer and it does not intend on marketing the contract to any new subscribers.  <i>The Company has complied with this recommendation.</i>	17
	<u>Mandated Benefits</u>	
16.	It is recommended that the HMO comply with §4303(z) of the New York State Insurance Law and include the required language relative to experimental or investigational procedures in its group HMO contract.  <i>The Plan has complied with this recommendation.</i>	18

**ITEM NO.****PAGE NO.**Fraud Department

17. It is recommended that the Empire companies put in place procedures to ensure that all closed fraud cases are reviewed and signed off on by a supervisor promptly. 23

*The Companies have complied with this recommendation.*

18. It is recommended that the Empire companies report only fraud related recoveries on its 409(g) filings with the Insurance Department. 23

*The Companies have complied with this recommendation.*

Claims Processing

19. It is recommended that Empire adjudicate all suspended claims in a timely manner once it has received the requested documentation. 27

*The Company has complied with this recommendation.*

20. It is recommended that Empire request all relevant documentation required to adjudicate a claim during its initial review. 27

*The Company has complied with this recommendation.*

Cosmetic Denials

21. Until otherwise permitted by the Superintendent, it is recommended that Empire cease the practice of issuing automatic denials for procedures deemed to be cosmetic unless utilization reviews are performed and the appropriate appeal rights are provided in accordance with Article 49 of the New York Insurance Law and Public Health Law. 29

*The Companies have complied with this recommendation.*

22. It is recommended that Empire request medical records and retroactively conduct utilization reviews for all of the procedures that were automatically denied as cosmetic for the period from July 1, 2003 through present, and as a result of such utilization review, make all additional payments that are warranted based upon reversal of a previously denied claim, where applicable along with interest calculated pursuant to Section 3224-a(c) of the Insurance Law. 29

*The Company has complied with this recommendation.*

**ITEM NO.****PAGE NO.**Empire's Evaluation and Management Re-Coding Program

23. It is recommended that Empire cease the practice of recoding claims for E & M services submitted by a non-participating provider to a less complex level of care based upon the diagnosis reported unless utilization reviews are performed and the appropriate appeal rights are provided in accordance with Article 49 of the New York State Insurance and Public Health Law. 31

*The Companies have complied with this recommendation.*

24. It is recommended that Empire request medical records and retroactively conduct utilization reviews for all of the E & M services that were submitted by non-participating providers and recoded by Empire to a less complex level of care based upon the diagnosis reported, for the period from July 1, 2003 through present, and as a result of such utilization review, make all additional payments to either the provider or subscriber that are warranted based upon reversal of previously denied claims. 31

*The Company has complied with this recommendation.*

Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Care Services

25. It is recommended that Empire take steps to ensure that the provisions of §3224-a(a) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 35

*The Company has not complied with this recommendation. A similar recommendation is contained in this report.*

26. It is recommended that Empire take steps to ensure that the provisions of §3224-a(c) of the New York State Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 36

*The Company has not complied with this recommendation.*

Explanation of Benefits Statements

27. It is recommended that Empire accurately report the amount it reimburses hospitals on its Explanation of Benefits statement issued to subscribers. 37

*The Company has complied with this recommendation.*

## 11. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Adoption of Procedure Manuals – Department Circular Letter No. 9 (1999)</u>	
Subsequent to the filing of the Special Market Conduct Examination report, Empire revised its processes to address the recommendation regarding Circular Letter No. 9 (1999) contained in that report.	7
B. <u>Sales, Marketing and Advertising</u>	
i. It is recommended that, where appropriate, the Companies provide linked information in Spanish on their website, in order to prevent any communication problems with Spanish-speaking members or prospective members.	8
ii. It is recommended that Empire comply with the provisions of Department Regulation No. 34 and provide specific references for any statistics used in advertisements and that the Companies refrain from using vague terms in their advertisements.	9
C. <u>Agents and Brokers</u>	
i. It is recommended that Empire maintain current licenses on file for all active producers to ensure compliance with the provisions of Section 2116 of the New York Insurance Law.	11
ii. It is recommended that Empire ensure that certificates of appointments are filed with the Department for each of its agents, as required by Section 2112(a) of the New York Insurance Law. The Companies should also ensure that commission payments are made only to agents that have been appointed by Empire.	11
iii. It is recommended that Empire comply with the provisions of Section 2112(d) of the New York Insurance Law by maintaining documentation for and reporting all terminated insurance agents to the Department, as prescribed by statute.	13
iv. It is also recommended that Empire maintain a log of terminated certificates of appointments of agents and brokers in accordance with the recordkeeping requirements of Department Regulation No. 152.	13

<u>ITEM</u>	<u>PAGE NO.</u>
D. <u>Utilization Review</u>	
i.    It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services requiring pre-authorization by clearly delineating when the state or federal statutory timeframes should be applied to a particular pre-service claim.	15
ii.   It is recommended that Empire revise its policy in regard to utilization review determinations involving health care services which have been delivered, by clearly delineating when the state or federal statutory timeframes should be applied to a particular post-service claim.	16
iii.   It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim.	17
iv.    It is again recommended that Empire revise its policy to clearly delineate whether the state or federal statute should be applied to a particular claim.	18
v.     It is recommended that Empire comply with the requirements of Section 4904(c) of the New York Insurance Law.	19
vi.    It is recommended that Empire amend its Utilization Review procedures to clearly note which statute is applicable to a specific situation.	20
vii.   Though Empire contends that it has adopted these policies – it should formally document that these policies were in fact adopted by EHCA and EHC-HMO.	20
viii.  It is recommended that Empire complies with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law.	21
Subsequent to the date of this examination, Empire provided documentation to show that it was in compliance with the provisions of Section 4901(a) of the New York Insurance Law and Section 4901(1) of the New York Public Health Law.	
ix.    It is also recommended that Empire complies with the provisions of Part 243.2(a) of Department Regulation No. 152, by retaining copies of all utilization review statements that are required to be filed with the Superintendent of Insurance and/or the Commissioner of Health.	21

<u>ITEM</u>	<u>PAGE NO.</u>
x. It is recommended that Empire comply with the provisions of Section 4903(e) of the New York Insurance Law and revise its <i>Notification of Utilization Review Determination</i> policy (URA-03) accordingly.	22
xi. It is recommended that Empire expressly comply with the provisions of Department Regulation No. 166 and revise its policy in regard to utilization review <i>Appeals of Adverse Determinations</i> (URA-04) to also include insurers that are licensed pursuant to Articles 42 and 43 of the New York Insurance Law.	23
E. <u>Grievances and Appeals</u>	
i. It is recommended that Magellan, which acts on behalf of Empire as a third party administrator (“TPA”), comply with the requirement of Section 4802(d)(2) of the New York Insurance Law by ensuring that resolutions to grievances filed are rendered within the statutorily mandated 30-day period after receipt of all necessary information. Empire, which is responsible for Magellan’s violations of statute, should ensure Magellan’s compliance with applicable requirements.	24
ii. It is also recommended that Magellan revise statements on its acknowledgement letters to members to correctly state that New York Insurance Law requires Health Plans to determine an appeal or grievance within 30 days and <b>not</b> 60 days as currently stated.	24
iii. It is recommended that all grievances received by Empire or its TPA(s) include the proper date stamp to reflect the day that the Companies receive such documents.	24
iv. It is recommended that Empire comply with the requirements of Section 4802(d) of the New York Insurance Law and ensure that acknowledgement letters are sent to members for all grievances received, within 15 business days of receipt of the application.	25
v. It is also recommended that Empire review and evaluate its controls to ensure that the automated system works correctly and sends grievance acknowledgement letters to members/providers in a timely manner.	25

<u>ITEM</u>	<u>PAGE NO.</u>	
vi.	It is recommended that Empire comply with the provisions of Section 4802(d)(2) of the New York Insurance Law by ensuring that resolutions to grievances filed are rendered within thirty days (after receipt of all necessary information).	26
F.	<u>Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care and Payments for Health Services (“Prompt Pay Law”)</u>	
i.	It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(a) of the New York Insurance Law, regarding the prompt payment of claims, are fully implemented and complied with.	31
ii.	It is also recommended that Empire take steps to ensure that the provisions of Section 3224-a(c) of the New York Insurance Law, regarding the payment of interest, are fully implemented and complied with.	31
iii.	It is recommended that Empire take steps to ensure that the provisions of Section 3224-a(b) of the New York Insurance Law, regarding the prompt denial of claims/requests for information are fully implemented and complied with.	34
iv.	It is recommended that Empire facilitate the examination process by informing the examiner of relevant operation protocols in a timely manner.	35

Appointment No. 22488

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Pearson Griffith**

as a proper person to examine into the affairs of the

**Empire HealthChoice HMO, INC.**

and to make a report to me in writing of the said

**Company**

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 10<sup>th</sup> day of March 2006



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Howard Mills  
Superintendent of Insurance



Appointment No. 22489

**STATE OF NEW YORK  
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

**Pearson Griffith**

as a proper person to examine into the affairs of the

**Empire HealthChoice Assurance Inc.**

and to make a report to me in writing of the said

**Company**

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 10<sup>th</sup> day of March 2006



Howard Mills  
Superintendent of Insurance

